



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to subcriterion 1b).

Brief Measure Information

NQF #: 2375

Corresponding Measures:

De.2. Measure Title: PointRight® Pro 30™

Co.1.1. Measure Steward: American Health Care Association

De.3. Brief Description of Measure: PointRight OnPoint-30 is an all-cause, risk adjusted rehospitalization measure. It provides the rate at which all patients (regardless of payer status or diagnosis) who enter skilled nursing facilities (SNFs) from acute hospitals and are subsequently rehospitalized during their SNF stay, within 30 days from their admission to the SNF.

1b.1. Developer Rationale: Rehospitalization among admissions to SNFs has been identified as frequent and costly by academic studies ((Grabowski 2007; Clark, 2010; Mor, 2010; Walsh, 2012), non-profit foundations such as Kaiser Foundation (Jacobson, 2010) and Commonwealth Fund (Schoen, 2013) as well as by government agency studies such as MedPAC (MedPAC, 2012) and CMS (Walsh, 2010).

Most of the reasons for high SNF rehospitalizations have been attributed to structural and process issues not directly related to clinical management of diagnoses listed on the hospital readmission claims (Ouslander, 2012; Ouslander, 2011). In the hospital setting, efforts to reduce rehospitalization also appear related to structure and processes not directly related to the clinical conditions (Dharmarajan, 2013;Hansen, 2011). In fact, a majority of rehospitalizations are for a different diagnosis or reason than their discharge diagnosis and more often reflect the broader condition of the patient and problems with the health care delivery system (Krumholtz, 2013). Solutions proposed by federal agencies have also suggested changes in payment and structural aspects of care (MedPac ,2012; Polniaszek, 2011). CMS's Center for Medicare & Medicaid Innovation is also testing models that promote nurse practitioners,the INTERACT program, and other models, all unrelated to specific clinical practice algorithms.

The frequent occurrence of rehospitalizations, the high cost, and the negative impact hospitalizations have on residents supports the need for a SNF rehospitalization measure. We see this measure as being used by providers (to benchmark their performance to others and to track their progress in quality improvement efforts), by insurance companies (to include in payment models and reporting programs) and by government agencies (to include in public reporting such as CMS's Nursing Home Compare and Medicare or Medicaid payment models).

Dharmarajan, K., Hsieh, A., Lin A., Bueno, H., Ross, J.S., Horwitz, L., ... Hines, H.J. (2013). Hospital readmission performance and patterns of readmission: Retrospective cohort study of Medicare admissions. *BMJ*, 347.

Jacobson, G., Neuman, T., & Damico, A. (2010). Medicare spending and use of medical services for beneficiaries in nursing homes and other long term care facilities: A potential for achieving Medicare saving and improving the quality of care. The Henry J. Kaiser Family Foundation.

Krumholz, H.M. (2013). Post-hospital syndrome- an acquired, transient condition of generalized risk. *NEJM*, 386(2): 100-102.

MedPAC. (2012) Report to congress: Payment policy. http://medpac.gov/documents/mar12_entirereport.pdf

Mor, V., Intrator, O., Feng, Z., & Grabowski, D.C. (2010). The revolving door of rehospitalizations from skilled nursing facilities. *Health Affairs*, 29(1): 57-64.

Oslander, J.G., & Maslow, K. (2012). Geriatrics and the triple aim: Defining preventable hospitalizations in the long-term care

population. J Am Geriatr Soc., 60(12): 2313-2318.

Ouslander, J.G., & Bersenson, R.A. (2011). Reducing unnecessary hospitalization of nursing home residents. NEJM, 356(13): 1165-1167.

Ouslander, J.G., Lamb, G., Perloe, M., Givens, J.H., Kluge, L., Rutland, T, ... Saliba, D. (2010). Potentially avoidable hospitalizations of nursing home residents: Frequency, causes, and costs. J Am Geriatr Soc., 58(4): 627-635.

Ouslander, J.G., Lamb, G., Tappen, R., Herndon, L., Diaz, S., Roos, B.A., ... Bonner, A. (2011). Interventions to reduce hospitalizations from nursing homes: Evaluation of the INTERACT II collaborative quality improvement project. J Am Geriatr Soc., 59(4): 745-753.

Polniaszek, S., Walsh, E.G., & Wiener, J.M. (2011). Hospitalizations of nursing home residents: Background and options. Office of the Assistant Secretary for Planning and Evaluation, <http://aspe.hhs.gov/daltcp/reports/2011/NHResHosp.pdf>

Schoen, C., Radley, D., Riley, P., Lippa, J., Berenson, J., Dermody, C., & Shih A. (2013). Health Care in the two Americas: Findings from the scorecard on the state health system performance for low-income populations. The Commonwealth Fund. <http://www.commonwealthfund.org/Publications/Fund-Reports/2013/Sep/Low-Income-Scorecard.aspx>

Walsh, E.D., Freiman, M., Haber, S., Bragg, A., Ouslander, J., & Wiener, J.M. (2010) Cost drivers for dually eligible beneficiaries: Potentially avoidable hospitalization from nursing facility, skilled nursing facility, and home and community-based services waiver programs, final task 2 report. RTI International.

Young, H.M., Kurtzman, E., Roes, M., Toles, M., Ammerman, A., & Pace, D. (2011). Measurement opportunities & gaps: Transitional care processes and outcomes among adult recipients of long-term services and supports. Long Term Quality Alliance, Quality Measurement Workgroup.

S.4. Numerator Statement: The numerator is the number of patients sent back to any acute care hospital (excluding emergency room only visits) during their SNF stay within 30 days from a SNF admission, as indicated on the MDS 3.0 discharge assessment during the 12 month measurement period.

S.7. Denominator Statement: The denominator is the number of all admissions, regardless of payer status and diagnosis, with an MDS 3.0 admission assessment to a SNF from an acute hospital during the target rolling 12 month period.

S.10. Denominator Exclusions: The denominator has 2 different exclusions: individual level and provider level. At the individual level the exclusion is related to incomplete assessments. At the provider level the exclusion is related to the amount of data necessary to calculate the measure that is missing. Payer status and clinical conditions are not used for any exclusions.

De.1. Measure Type: Outcome

S.23. Data Source: Electronic Health Record (Only)

S.26. Level of Analysis: Facility

IF Endorsement Maintenance – Original Endorsement Date: Dec 23, 2014 **Most Recent Endorsement Date:** Dec 09, 2016

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? N/A

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form
[PointRightOnPoint-30_MeasSubm_Evidence_FINAL.docx](#)

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., the benefits or improvements in quality envisioned by use of this measure)

Rehospitalization among admissions to SNFs has been identified as frequent and costly by academic studies ((Grabowski 2007; Clark, 2010; Mor, 2010; Walsh, 2012), non-profit foundations such as Kaiser Foundation (Jacobson, 2010) and Commonwealth Fund (Schoen, 2013) as well as by government agency studies such as MedPAC (MedPAC, 2012) and CMS (Walsh, 2010).

Most of the reasons for high SNF rehospitalizations have been attributed to structural and process issues not directly related to clinical management of diagnoses listed on the hospital readmission claims (Ouslander, 2012; Ouslander, 2011). In the hospital setting, efforts to reduce rehospitalization also appear related to structure and processes not directly related to the clinical conditions (Dharmarajan, 2013; Hansen, 2011). In fact, a majority of rehospitalizations are for a different diagnosis or reason than their discharge diagnosis and more often reflect the broader condition of the patient and problems with the health care delivery system (Krumholz, 2013). Solutions proposed by federal agencies have also suggested changes in payment and structural aspects of care (MedPac, 2012; Polniaszek, 2011). CMS's Center for Medicare & Medicaid Innovation is also testing models that promote nurse practitioners, the INTERACT program, and other models, all unrelated to specific clinical practice algorithms.

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Jacobson, G., Neuman, T., & Damico, A. (2010). Medicare spending and use of medical services for beneficiaries in nursing homes and other long term care facilities: A potential for achieving Medicare saving and improving the quality of care. The Henry J. Kaiser Family Foundation.

Krumholz, H.M. (2013). Post-hospital syndrome- an acquired, transient condition of generalized risk. *NEJM*, 386(2): 100-102.

MedPAC. (2012) Report to congress: Payment policy. http://medpac.gov/documents/mar12_entirereport.pdf

Mor, V., Intrator, O., Feng, Z., & Grabowski, D.C. (2010). The revolving door of rehospitalizations from skilled nursing facilities. *Health Affairs*, 29(1): 57-64.

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Ouslander, J.G., & Bersenson, R.A. (2011). Reducing unnecessary hospitalization of nursing home residents. *NEJM*, 356(13): 1165-1167.

Ouslander, J.G., Lamb, G., Perloe, M., Givens, J.H., Kluge, L., Rutland, T., ... Saliba, D. (2010). Potentially avoidable hospitalizations of nursing home residents: Frequency, causes, and costs. *J Am Geriatr Soc.*, 58(4): 627-635.

Ouslander, J.G., Lamb, G., Tappen, R., Herndon, L., Diaz, S., Roos, B.A., ... Bonner, A. (2011). Interventions to reduce hospitalizations from nursing homes: Evaluation of the INTERACT II collaborative quality improvement project. *J Am Geriatr Soc.*, 59(4): 745-753.

Polniaszek, S., Walsh, E.G., & Wiener, J.M. (2011). Hospitalizations of nursing home residents: Background and options. Office of the Assistant Secretary for Planning and Evaluation, <http://aspe.hhs.gov/daltcp/reports/2011/NHResHosp.pdf>

Schoen, C., Radley, D., Riley, P., Lippa, J., Berenson, J., Dermody, C., & Shih A. (2013). Health Care in the two Americas: Findings from

the scorecard on the state health system performance for low-income populations. The Commonwealth Fund.
<http://www.commonwealthfund.org/Publications/Fund-Reports/2013/Sep/Low-Income-Scorecard.aspx>

Walsh, E.D., Freiman, M., Haber, S., Bragg, A., Ouslander, J., & Wiener, J.M. (2010) Cost drivers for dually eligible beneficiaries: Potentially avoidable hospitalization from nursing facility, skilled nursing facility, and home and community-based services waiver programs, final task 2 report. RTI International.

Young, H.M., Kurtzman, E., Roes, M., Toles, M., Ammerman, A., & Pace, D. (2011). Measurement opportunities & gaps: Transitional care processes and outcomes among adult recipients of long-term services and supports. Long Term Quality Alliance, Quality Measurement Workgroup.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.*

AHCA has been calculating and tracking rehospitalizations for all SNFs nationally for data from 2011 and updating results each quarter. Below are the basic statistics for the measure from the most recent data available; care through the 2nd quarter of 2013.

Risk Adjusted Rate Q2 2013

N= 11,432

Mean=17.59194

Standard Deviation= 5.31347

Minimum= 0

Maximum= 59.5

The distribution of the SNFs with reportable data is as follows:

Risk adjusted rehospitalization rate range 00 to <05: 96 Facilities
 Risk adjusted rehospitalization rate range 05 to <10: 739 Facilities
 Risk adjusted rehospitalization rate range 10 to <15: 2,622 Facilities
 Risk adjusted rehospitalization rate range 15 to <20: 4,445 Facilities
 Risk adjusted rehospitalization rate range 20 to <25: 2,666 Facilities
 Risk adjusted rehospitalization rate range 25 to <30: 730 Facilities
 Risk adjusted rehospitalization rate range 30 to <35: 140 Facilities
 Risk adjusted rehospitalization rate range 35 and above: 35 Facilities

In addition, all AHCA member facilities have access to their own rehospitalization rate updated each quarter through AHCA's Quality Dashboard (Long Term Care Trend Tracker). The national trends have shown a steady decline in the overall rate from fourth quarter of 2011 to the second quarter of 2013 of 3.3%, with the average improvement by state varying (see below; also available in Appendix).

Definitions of column headings:

SI-State ID

AR11= Average Rate 2011 Q4

AR13= Average Rate 2013 Q2

% Change= % Change from 2011 Q4 to 2013 Q2

#= Total # of facilities with reportable data

SI	AR11	AR13	%Change	#
US	18.2	17.6	-3.30%	10896
AK	13.1	15.3	16.80%	3
AL	17.8	17.2	-3.40%	179
AR	20.4	19.7	-3.40%	134

AZ	18.6	16.4	-11.80%	116
CA	17.6	16.7	-5.10%	735
CO	14	12.6	-10.00%	139
CT	17.5	16.9	-3.40%	184
DC	17.3	19.6	13.30%	10
DE	19	18.7	-1.60%	29
FL	20	19.4	-3.00%	571
GA	19	18.2	-4.20%	294
HI	12.8	10.7	-16.40%	23
IA	16.7	16.2	-3.00%	229
ID	11.9	11.2	-5.90%	56
IL	20.8	19.3	-7.20%	517
IN	17.4	17.5	0.60%	400
KS	16.8	16.7	-0.60%	149
KY	18.9	18.6	-1.60%	236
LA	23.3	22.8	-2.10%	216
MA	16.4	15.7	-4.30%	339
MD	19.6	18.4	-6.10%	172
ME	15.2	14.9	-2.00%	81
MI	18.6	17.4	-6.50%	324
MN	15.9	15.1	-5.00%	281
MO	19.3	19.3	0.00%	324
MS	21.6	21	-2.80%	153
MT	12.9	12.7	-1.60%	31
NC	18.6	17.9	-3.80%	348
ND	14.3	13.8	-3.50%	30
NE	15.9	15.8	-0.60%	114
NH	15.5	14.3	-7.70%	60
NJ	20.6	19.5	-5.30%	314
NM	15.8	15.5	-1.90%	36
NV	17.9	16.6	-7.30%	35
NY	18.4	18	-2.20%	444
OH	18.1	17.5	-3.30%	792
OK	20.3	20.6	1.50%	129
OR	16.9	15.6	-7.70%	104
PA	17.7	17.4	-1.70%	594
RI	20	17.7	-11.50%	61
SC	18	17.7	-1.70%	151
SD	12.5	13.6	8.80%	48
TN	18	17.6	-2.20%	247
TX	19.3	18.5	-4.10%	568
UT	11.9	11.9	0.00%	61
VA	18	17.7	-1.70%	229
VT	13.3	13.6	2.30%	29
WA	16.3	15.5	-4.90%	194
WI	15.4	16	3.90%	274
WV	18.1	17.9	-1.10%	91
WY	13	14.2	9.20%	18

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

Several studies have documented that a large portion of hospitalizations from SNFS(both short and long stay residents) could have been prevented. In one study that utilized physician review of each hospitalization, 67% were classified as potentially preventable (Saliba, 2010). In addition, studies evaluating the implementation of the INTERACT program (a comprehensive program designed to

reduce hospitalizations from SNFs) have shown significant reductions in hospitalizations of 17% to 24% (Ouslander, 2011; Tena-Nelson, 2012). The Evercare program an all inclusive Medicare program for individuals residing in SNFs has shown the ability to significantly reduce rehospitalizations by half, mainly through the use of nurse practitioners (Kane, 2003; Kane, 2004). These studies combined with the experience of AHCA's national quality initiative focusing on reducing rehospitalizations (AHCA, 2013) support the fact that a significant opportunity for improvement exists in reducing SNF rehospitalizations.

American Health Care Association (2013). 2013 Quality Report. Retrieved from http://www.ahcancal.org/qualityreport/Documents/AHCA_2013QR_ONLINE.pdf

Kane, R.L., Keckhafer, G., Flood, S., Bershadsky, B., & Siadty, M.S. (2003). The effect of Evercare on hospital use. *J Am Geriatr Soc.*, 51(10): 1427-1434.

Kane, R.L, Flood, S., Bershadsky, B., Keckhafer, G.(2004). Effect of an innovative Medicare managed care program on the quality of care for nursing home residents. *Gerontologist*. 44(1):95-103.

Ouslander, J.G., Lamb, G., Tappen, R., Herndon, L., Diaz, S., Roos, B.A., ... Bonner, A. (2011). Interventions to reduce hospitalizations from nursing homes: Evaluation of the INTERACT II collaborative quality improvement project. *J Am Geriatr Soc.*, 59(4): 745-753.

Saliba, D., Kington, R., Buchanan, J., Bell, R., Wang, M., Lee, M., ... Rubenstein, L. (2000). Appropriateness of the decision to transfer nursing facility residents to the hospital. *J Am Geriatr Soc.*, 48(2): 154-163.

Tena-Nelson, R., Santos, K., Weingast, E., Amrhein, S., Ouslaner, J., & Bookvar, K. (2012). Reducing potentially preventable hospital transfers: Results from a thirty nursing home collaborative. *JAMDA*, 13(7): 651-656.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. *(This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.*

The measure reflects the entire population of individuals admitted to a SNF following a hospitalization. It includes all ethnicities regardless of payer status. Nationally, three-quarters of all nursing home residents are classified as Caucasian (See appendix for ethnicity data from CMS MDS 3.0 data 2013 3rd quarter, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports/Minimum-Data-Set-3-0-Frequency-Report.html>). Stratifying the measure by ethnicity would result in most providers having inadequate sample size to report a rehospitalization rate. Also, the measure is an all cause readmission measure, intended to capture the overall performance of each SNF. Thus, we have not calculated the measure stratified by ethnicity.

Data on insurance status is available on MDS but is not reliable. This is due to the accuracy of the information submitted by providers, the confusion of the payer status at admission, and the number of people who have their stay paid for by multiple providers during the course of their stay. Thus, we have not calculated the measure stratified by payer status.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

The literature on ethnic disparities in care in SNFs is scarce overall, with only two articles focusing on ethnic differences in rehospitalization rates. A Medline search of racial disparities and SNFs only yields 37 articles of which a fifth address issues related to ethnic disparities in access to SNF services. Of the remaining articles most address disparities in long term care but not for residents receiving short post-acute care services. Two articles focus on ethnic disparities related to hospitalizations (Li, 2011; Grunier, 2008). In the first study using national MDS data from 2008, the authors found that the 30 day rehospitalization rates were 14.3% for white patients (n = 865,993) and 18.6% for black patients (n = 94,651). Both patient and admitting facility characteristics accounted for a considerable portion of overall racial disparities, but disparities persisted after multivariable adjustments overall and in patient subgroup (Li, 2011). However, this study did not compare within-facility and between-facility disparities. Within-facility disparities are those where disparities exist between Blacks and Whites in the same facilities and between-facility disparities are those where disparities exist between facilities with different racial composition (i.e. facilities with higher minority populations have poorer care quality than facilities with mostly white populations). Based on previous research related to racial disparities in SNFs, it is expected that disparities in rehospitalization would exist between facilities.

In the second article, hospitalization rates for long stay residents on Medicaid were examined (short stay residents were not included) (Grunier, 2008). In this study, using MDS data to look at long stay residents, 18.5% of white and 24.1% of black residents were hospitalized. Residents in nursing homes with high concentrations of blacks had 20% higher odds (95 percent confidence interval [CI]=1.15-1.25) of hospitalization than residents in nursing homes with no blacks. Ten-dollar increments in Medicaid rates reduced the odds of hospitalization by 4 percent (95 percent CI=0.93-1.00) for white residents and 22 percent (95 percent CI=0.69-0.87) for black residents.

Multiple studies in the past twenty years have examined racial disparities in the care of SNF residents and have consistently found poorer care in facilities with high minority populations (Fennell et al., 2000; Mor et al., 2004; Smith et al., 2007). Work on disparities in quality of care between elderly white and black residents within SNFs has shown clearly that nursing homes remain relatively segregated, and that nursing home care can be described as a tiered system in which blacks are concentrated in marginal-quality homes (Mor et al., 2004). Such homes tend to have serious deficiencies in staffing ratios, performance, and are more financially vulnerable (Smith et al, 2007; Chisholm et al., 2013). Based on a review of the SNF disparities literature, Konetzka and Werner (2009) concluded that disparities in care are likely related to racial and socioeconomic segregation as opposed to within-provider discrimination. This conclusion is supported, for example, by Grunier and colleagues who found that as the proportion of black residents in the nursing home increased the risk of hospitalization among all residents, regardless of race, also increased (Grunier et al., 2008). Rehospitalization risk likely also increases as the proportion of black residents increases, indicating that the best measure of racial disparities in rates of rehospitalization is one that measures rehospitalization at the facility level.

The sample size for African Americans divided across all the SNFs would make most SNFs unable to report a rate stratified by race (see appendix for state sample size). African American ethnicity is the next largest ethnicity after Caucasian.

Cai, S., Mukamel, D., & Temkin-Greener, H. (2010). Pressure ulcer prevalence among black and white nursing home residents in New York state: Evidence of racial disparity? *Medical Care* 48(3), 233-239.

Chisholm, L., Weech-Maldonado, R., Laberge, A., Lin, F. C., & Hyer, K. (2013). Nursing Home Quality and Financial Performance: Does the Racial Composition of Residents Matter?. *Health services research*.

Fennell, M. L., Miller, S. C., & Mor, V. (2000). Facility effects on racial differences in nursing home quality of care. *American Journal of Medical Quality*, 15(4), 174-181.

Grabowski, D.C. (2004). The admission of Blacks to high-deficiency nursing homes. *Medical Care* 42(5): 456-464.

Gruneir, A., Miller, S. C., Feng, Z., Intrator, O., & Mor, V. (2008). Relationship between state Medicaid policies, nursing home racial composition, and the risk of hospitalization for black and white residents. *Health Services Research*, 43(3), 869-881.

Konetzka, R. T., & Werner, R. M. (2009). Review: Disparities in long-term care building equity into market-based reforms. *Medical Care Research and Review*, 66(5), 491-521.

Li, Y., Glance, L.G., Yin, J., & Mukamel, D.B (2011). Racial disparities in rehospitalization among Medicare patients in skilled nursing facilities. *American Journal of Public Health*, 101 (5), 875-882.

Mor, V., Papadantonatos, G., & Miller, S.C. (2005). End-of-life hospitalization for African American and non-Latino White nursing home residents: Variation by race and a facility's racial composition. *Journal of Palliative Medicine*, 8(1): 58-68.

Mor, V., Zinn, J., Angelelli, J., Teno, J. M., & Miller, S. C. (2004). Driven to tiers: socioeconomic and racial disparities in the quality of nursing home care. *Milbank Quarterly*, 82(2), 227-256.

Smith, D. B., Feng, Z., Fennell, M. L., Zinn, J. S., & Mor, V. (2007). Separate and unequal: racial segregation and disparities in quality across US nursing homes. *Health Affairs*, 26(5): 1448-1458.

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF;
- OR

- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

Affects large numbers

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare.

List citations in 1c.4.

One in five Medicare FFS beneficiaries are discharged from hospital to a SNF (Mor, 2010; MedPAC, 2012) of which nearly one in four are sent back to the hospital during their SNF stay (Mor, 2010, MedPac, 2012) (See appendix). The cost of these readmissions is significant (Grabowski, 2007; Walsh, 2010).

In 2012, there were 2.4 million Medicare beneficiaries using part A benefits admitted to SNFs and an additional 798,513 individuals admitted to nursing homes (AHCA, 2013). This equates to between 736,000 or 576,000 individuals rehospitalized in 2012 assuming either rehospitalization rate of 23% or 18% (Mor, 2010; AHCA, 2013). [note: calculation is $(2.4M + 0.8M) = 3.2M \times 23\% = 736,000$ or $3.2M \times 0.18 = 576,000$]. The cost to the overall healthcare system of these readmissions is significant, estimated at \$5.6 billion (note calculation assumes the average Medicare cost of a hospital admission is \$9,762 (Walsh, 2010) which we applied to all rehospitalizations both Medicare and non-Medicare \times 736,000 rehospitalizations.)

1c.4. Citations for data demonstrating high priority provided in 1a.3

Grabowski, D.C., O'Malley, A.J., & Barhydt, N.R. (2007). The costs and potential savings associated with nursing home hospitalizations. *Health Affairs*, 93: 1753-1761.

Jencks, S.F., Williams, M.V., & Coleman, E.A. (2009). Rehospitalizations among patients in the Medicare fee-for-service program. *NEJM*, 360(14): 1418-1428.

Jacobson, G., Neuman, T., & Damico, A. (2010). Medicare spending and use of medical services for beneficiaries in nursing homes and other long term care facilities: A potential for achieving Medicare saving and improving the quality of care. The Henry J. Kaiser Family Foundation.

MedPAC. (2012) Report to congress: Payment policy. http://medpac.gov/documents/mar12_entirereport.pdf

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Ouslander, J.G., & Bersenson, R.A. (2011). Reducing unnecessary hospitalization of nursing home residents. *NEJM*, 356(13): 1165-1167.

Polniaszek, S., Walsh, E.G., & Wiener, J.M. (2011). Hospitalizations of nursing home residents: Background and options. Office of the Assistant Secretary for Planning and Evaluation, <http://aspe.hhs.gov/daltcp/reports/2011/NHResHosp.pdf>

Walsh, E.D., Freiman, M., Haber, S., Bragg, A., Ouslander, J., & Wiener, J.M. (2010) Cost drivers for dually eligible beneficiaries: Potentially avoidable hospitalization from nursing facility, skilled nursing facility, and home and community-based services waiver programs, final task 2 report. RTI International.

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

N/A

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

De.6. Non-Condition Specific (check all the areas that apply):

Care Coordination : Readmissions, Care Coordination : Transitions of Care

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

N/A

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

No data dictionary Attachment:

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

N/A

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

The numerator is the number of patients sent back to any acute care hospital (excluding emergency room only visits) during their SNF stay within 30 days from a SNF admission, as indicated on the MDS 3.0 discharge assessment during the 12 month measurement period.

S.5. Time Period for Data (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

The numerator time window is 30 days after the date of admission to a SNF from an acute care hospital. If a rehospitalization does not occur during this time window, the admission is not counted as part of the numerator. Rehospitalizations that occur after an individual is discharged to the community but are within the 30 day time window are not counted. The measure only takes into consideration rehospitalizations that occur during a SNF stay.

The data sample time window is the target rolling 12 month time period, updated quarterly. All admissions to SNFs from acute hospitals that have an entry date that falls in the target period and have an MDS 3.0 admission assessment are included in the denominator.

S.6. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome

should be described in the calculation algorithm.

The numerator is the number of patients that are discharged from a SNF to an acute hospital within 30 days of entry from an acute hospital as indicated by MDS item A2100=03 (indicating 'discharge to acute hospitals') and MDS item A0310F=10/11 (indicating discharge status). The length of stay before rehospitalization is calculated by subtracting MDS item A1600 (entry date) from MDS item A2000 (discharge date).

S.7. Denominator Statement *(Brief, narrative description of the target population being measured)*

The denominator is the number of all admissions, regardless of payer status and diagnosis, with an MDS 3.0 admission assessment to a SNF from an acute hospital during the target rolling 12 month period.

S.8. Target Population Category *(Check all the populations for which the measure is specified and tested if any):*

Elderly, Populations at Risk : Dual eligible beneficiaries, Populations at Risk : Individuals with multiple chronic conditions

S.9. Denominator Details *(All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

The total number of admissions to the facility, from an acute hospital, during the 12 month measure period are determined using the MDS item A1800=03, indicating 'entered from hospital'. The entry date is determined using 2 MDS variables: A1600 (entry date) and A0310F=01 (indicating 'entry tracking records').

S.10. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

The denominator has 2 different exclusions: individual level and provider level. At the individual level the exclusion is related to incomplete assessments. At the provider level the exclusion is related to the amount of data necessary to calculate the measure that is missing. Payer status and clinical conditions are not used for any exclusions.

S.11. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

Individual level exclusions are made for admissions that do not have either a discharge assessment or a quarterly (annual or change of status) assessments within 120 days of admissions, as they are considered incomplete.

S.12. Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)*

N/A

S.13. Risk Adjustment Type (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

Statistical risk model

If other:

S.14. Identify the statistical risk model method and variables *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)*

Risk adjustment for PointRight OnPoint-30 was completed by means of logistic regression using independent variables drawn from the first MDS 3.0 assessment performed after admission to the SNF. In some cases, this was a combined admission/discharge assessment.

The following lists the variables used in the logistic regression risk adjustment model. The MDS 3.0 codes used to determine whether or not each variable contributes to the calculation are provided below in S.18.

Demographic

-Age less than 65

-Male

-Medicare

Functional Status

- Total Bowel Incontinence
- Eating Dependence
- Two-person Assist
- Cognition Not Intact or Complete

Prognosis

- End-stage Prognosis
- Re-entry
- Respiratory Failure
- Hospice Care

Clinical Condition

- Daily Pain
- Stage Two Pressure Ulcer
- Stage Three Pressure Ulcer
- Stage Four Pressure Ulcer
- Unstageable Pressure Ulcer
- Venous Arterial Ulcer
- Diabetic Foot Ulcer

Diagnosis

- Anemia
- Asthma
- Diabetes Mellitus
- Heart Failure
- Septicemia
- Viral Hepatitis
- Internal Bleeding

Services and Treatment

- Dialysis
- Insulin
- Ostomy Care
- Cancer Chemotherapy
- Radiation Therapy
- Continue IV Medication
- Continue Oxygen
- Continue Tracheostomy

S.15. Detailed risk model specifications (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

Provided in response box S.15a

S.15a. Detailed risk model specifications (if not provided in excel or csv file at S.2b)

Look at S.18

S.16. Type of score:

Rate/proportion

If other:

S.17. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score,

a lower score, a score falling within a defined interval, or a passing score)

Better quality = Lower score

S.18. Calculation Algorithm/Measure Logic (Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)

The formula for a facility's adjusted rehospitalization rate is as follows:

(Observed Rate of Rehospitalization within 30 days) / (Expected Rate of Rehospitalization within 30 days) * (National rate). Note- the national rate and the expected rate need to be calculated for the same measure period.

1. Observed Rate Calculation

- The formula for a facility's observed Rehospitalization rate is as follows:

(Observed count of discharges to hospitals within 30 days of admission) / (Observed count of admissions from hospitals)

- The denominator is the number of any admissions from a hospital during a rolling 12 month time period. (This is a count of events, not of residents.)

- The numerator is the number of all admissions to the SNF during a rolling 12 month time period who then went back to the hospital within 30 days of their admission date. (This is a count of events, not of residents.)

2. Expected Rate Calculation

2.1 First the expected rate for every single resident admission is calculated using the formula below.

The calculation must be performed at least 45 days after the end of the target rolling 12-month period. This is to allow 30 days to elapse to capture rehospitalizations that occur from admission to the SNF on the last day of the target period and another 14 days to allow facilities to submit data to CMS. We recommend waiting an additional 2 to 3 weeks to ensure maximum data availability for MDS assessments not submitted during the 14 day period.

VARIABLE CALCULATION

Intercept: -2.8252

Age Under 65: if age<65 then Variable=1; else Variable=0; (If Date of Birth is missing, then Variable=0)

End Stage Prognosis: if J1400=1 then Variable=1; else Variable=0;

Hospice Care: if O0100K2=1 then Variable=1; else Variable=0;

Male: if A0800=1 then Variable=1; else Variable=0;

Medicare: if A0310B = 01 or 06, then Variable=1; else Variable=0;

SNF Admission is Return to Same SNF Following Hospitalization: if A0310B=06 AND A1600 minus A2000 (on a previous MDS where A2100=3) < 30 then Variable=1; else if A1700=2 then Variable=1; else Variable=0;

Diagnoses

Anemia: if I0200=1 then Variable=1; else Variable=0;

Asthma: if I6200=1 then Variable=1; else Variable=0;

Diabetes Mellitus: if I2900=1 then Variable=1; else Variable=0;

Diabetic Foot Ulcer: if M1040B=1 then Variable=1; else Variable=0;

Pressure Ulcer Stage 2: if M0300B2>0 then Variable=1; else Variable=0;

Pressure Ulcer Stage 3: if M0300C2>0 then Variable=1; else Variable=0;

Pressure Ulcer Stage 4: if M0300D2>0 then Variable=1; else Variable=0;

Pressure Ulcer Unstageable: if M0300E2>0 or M0300F2>0 or M0300G2>0 then Variable=1; else Variable=0;

Respiratory Failure: if I6300=1 then Variable=1; else Variable=0;

Septicemia: if I2100=1 then Variable=1; else Variable=0;

Vascular Ulcer: if M1030>0 then Variable=1; else Variable=0;

Viral Hepatitis: if I2400=1 then Variable=1; else Variable=0;

Heart Failure: if I0600=1 then Variable=1; else Variable=0;

Internal Bleeding: if J1550D=1 then Variable=1; else Variable=0;

Functional Status

Daily Pain: if J0400=1 or J0850=3 then Variable=1; else Variable=0;
 Eating Dependence- Total: if G0110H1 = 4,7, or 8, then Variable=1; else Variable=0;
 Two Person assist Needed with One or More ADLs: if G0110A2=3 or G0110B2=3 or G0110C2=3 or G0110D2=3 or G0110E2=3 or G0110F2=3 or G0110G2=3 or G0110H2=3 or G0110I2=3 or G0110J2=3 then Variable=1; else Variable=0;
 Cognition not Completely Intact: if C0100=1 AND if C0500=15 then Variable=0;
 if C0100=1 AND if C0500 <>15 then Variable=1; if C0100=0 AND if C0700=0 AND C0800=0 AND C1000=0 AND C0900A=1 AND C0900B=1 AND C0900C=1 AND C0900D=1 then Variable=0; else Variable=1;
 Total Bowel Incontinence: if H0400>0 then Variable=1; else Variable=0;

Treatment

Cancer Chemotherapy: if O0100A1=1 then Variable=1; else Variable=0;
 Dialysis: if O0100J1=1 then Variable=1; else Variable=0;
 Insulin: if N0350A>0 or N0350B>0 then Variable=1; else Variable=0;
 IV Medications Continuing from Hospital: if O0100H1=1 and O0100H2=1 then Variable=1; else Variable=0;
 Ostomy Care: if H0100C=1 then Variable=1; else Variable=0;
 Oxygen Continuing from Hospital: if O0100C1=1 and O0100C2=1 then Variable=1; else Variable=0;
 Radiation Therapy: if O0100B1=1 then Variable=1; else Variable=0;
 Tracheostomy Continuing from Hospital: if O0100E1=1 and O0100E2=1 then Variable=1; else Variable=0;

FORMULA

LogOdds=	-	2.8252	
	-	0.7846	* End Stage Prognosis
	-	1.5085	* Hospice_care
	+	0.0923	* Anemia
	+	0.1033	* Asthma
	+	0.0611	* Daily Pain
	+	0.0462	* Diabetes_Mellitus
	+	0.1459	* Diabetic Foot Ulcer
	+	0.6038	* Dialysis
	+	0.1777	* Insulin
	+	0.3263	* Ostomy Care
	+	0.167	* Pressure Ulcer Stage 2
	+	0.1334	* Pressure Ulcer Stage 3
	+	0.1569	* Pressure Ulcer Stage 4
	+	0.181	* Pressure Ulcer Unstageable
	+	0.0891	* Septicemia
	+	0.1848	* Total Bowel Incontinence
	+	0.1862	* Venous Arterial Ulcer
	+	0.4017	* Viral Hepatitis
	+	0.177	* Age Under 65
	+	0.6001	* Cancer Chemotherapy
	+	0.188	* IV Medication Continued from Hospital
	+	0.3395	* Oxygen Continuing from Hospital
	+	0.1336	* Tracheostomy Continuing from Hospital
	+	0.4718	* Eating Dependency
	+	0.2004	* Heart Failure
	+	0.892	* Internal Bleeding
	+	0.1622	* Male
	+	0.14	* Return to Same SNF Following Hospitalizations
	+	0.5543	* Medicare
	+	0.2389	* Two Person Assist Required for One or More ADLs
	+	0.6111	* Radiation Therapy
	+	0.1159	* Respiratory Failure

+ 0.3327 * Cognition Not Completely Intact

$$30\text{day_Rehosp_Risk_Probability} = 1/(1+\exp(-\text{LogOdds}))$$

2.2 Once the above calculation is performed for all admissions within the sample time-frame, the results should be averaged to obtain the facility's expected rate for the measure. Hence, the expected rate for a facility is the average of the expected rehospitalization probabilities for each admission during the target time period.

Procedure for Calculating the Measure

1. Establish the 12 month rolling time period and collect all assessments with entry dates that fall within the time period. The count of these entries is the observed denominator.
2. For each entry date, determine whether the resident was discharged back to an acute hospital within 30 days of the entry date. The count of these discharges is the observed numerator.
3. Divide the numerator by the denominator to obtain the observed rate for the SNF.
4. Calculate the expected rate for the facility using the expected probability model for admissions during the sample period, then averaging them for the 12-month period.
5. Divide the observed rate by the expected rate and multiply by the national rate to obtain the adjusted all cause rate for the facility.

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)
No diagram provided

S.20. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

N/A

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

N/A

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

Refer to denominator exclusions, S.10 and S.11.

S.23. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Electronic Health Record (Only)

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

Resident Assessment Instrument Minimum Data Set (MDS) version 3.0

S.25. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

Available in attached appendix at A.1

S.26. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Facility

S.27. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Nursing Home / SNF

If other:

S.28. COMPOSITE Performance Measure - Additional Specifications *(Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)*

N/A

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

[PointRightOnPoint-30_MeasureTesting_FINAL.docx](#)

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

[Generated or collected by and used by healthcare personnel during the provision of care \(e.g., blood pressure, lab value, diagnosis, depression score\)](#)

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields? *(i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields)*

[ALL data elements are in defined fields in electronic clinical data \(e.g., clinical registry, nursing home MDS, home health OASIS\)](#)

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.

[Using the MDS data has allowed us to provide more timely data back to individual providers than using claims, which we initially used. Also, collecting and calculating the measure on a quarterly basis but spans a 12 month period has helped assure fewer facilities with missing rates due to small sample size and has the effect of preventing large fluctuations from measurement period to measurement period due to small sample sizes. Providers have asked for rates that span only a 1 quarter duration but the number of facilities with inadequate denominator size of 30 increases and the measure stability is also affected when using only 1 quarter](#)

time window. However, even with a 12 month window (reported as rolling average each quarter) we still have a number of facilities that cannot have a reported rate or may have a measure one quarter but not another since their total number of admissions from a hospital (denominator size) is close to the minimum number required for reporting (which is 30).

Also, providing information to individuals providers on their data completeness about the use of the MDS discharge assessments (the source for numerator) has helped providers improve their completion of MDS discharge assessment. We have modified our feedback reports to facilities about their data completeness. We also have had to provide more explanation for how the measure is calculated, so that they can interpret their data. Understanding the risk adjustment method of [actual rate/expected rate] x national average is not self-evident to most providers. However, once explained with examples, they appreciate the method.

We also have modified how long we wait until after the end of the quarter to increase data completeness. Some providers even several months after the close of a quarter have not submitted all of their MDS data to CMS. We have modified our calculations to update their prior quarter's rates when additional MDS data is submitted to CMS. This affects less than 10% of providers and even then most rates do not change significantly. However, providers appreciate having the most accurate and complete data updated for their historical trend analysis.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

N/A

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Planned	Current Use (for current use provide URL)
Public Reporting	Professional Certification or Recognition Program Quality Improvement Recognition Program
Payment Program	http://www.ahcancal.org/quality_improvement/qualityinitiative/Pages/RecognitionProgram.aspx Quality Improvement (Internal to the specific organization) AHCA Quality Initiative http://www.ahcancal.org/quality_improvement/qualityinitiative/Pages/default.aspx

4a.1. For each CURRENT use, checked above, provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

The Quality Improvement Recognition Program, LTC Trend Tracker and AHCA Quality Initiative are all sponsored by the American Health Care Association (AHCA).

The purpose of the Quality Initiative Recognition Program is to recognize AHCA member SNFs for accomplishing one or more of the AHCA Quality Initiative goals. 2013 is the first year of this program and 2,720 member SNFs across the nation safely reduced re-

hospitalizations by at least 15% or maintained their rate below the 25th percentile from 2011.

LTC Trend Tracker is a free AHCA member resources that allows members to track, benchmark and compare a variety of metrics. Currently, there are 5,906 registered users of LTC Trend Tracker. The re-hospitalization measure has been available for use here since February, 2013.

AHCA Quality Initiative is a program that sets specific, measurable targets to further quality improvement. It focuses on the following four goals:

- safely reduce hospital readmissions within 30 days during a skilled nursing stay by 15 percent;
 - increase staff stability by reducing nursing staff turnover by 15 percent;
 - increase customer satisfaction by having 90 percent of residents and families willing to recommend their center to others;
- and
- safely reduce the off-label use of antipsychotics by 15 percent.

4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

N/A

4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

N/A

4b. Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)
- Geographic area and number and percentage of accountable entities and patients included

Initial Endorsement

4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

N/A

4c. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

None identified.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.
No

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications completely harmonized?

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

N/A

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

N/A

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

[Attachment](#) **Attachment:** [PointRightOnPoint-30_Appendix_FINAL.docx](#)

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): [American Health Care Association](#)

Co.2 Point of Contact: [Urv, Shah, ushah@ahca.org](#), 202-842-4444-

Co.3 Measure Developer if different from Measure Steward: [PointRight Inc.](#)

Co.4 Point of Contact: [Barry, Fogel, barry.fogel@pointright.com](#), 781-457-5954-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

Barry Fogel, MD: Measure design, selection of independent variables. Clinical Professor, Harvard Medical School, Executive Vice President, PointRight Inc.

John Gao, PhD: Data management and statistical analysis. Senior Statistician, PointRight Inc.

Steven Littlehale MS, GCNS: Advanced Practice Clinician Advisory Group. BC Executive Vice President & Chief Clinical Officer

Cheryl Field MSN, RN, CRRN: Advanced Practice Clinician Advisory Group. VP Healthcare and Privacy Officer, PointRight Inc.

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Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2012

Ad.3 Month and Year of most recent revision: 08, 2013

Ad.4 What is your frequency for review/update of this measure? Three Years

Ad.5 When is the next scheduled review/update for this measure? 12, 2014

Ad.6 Copyright statement: Copyright applied for.

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Ad.7 Disclaimers: N/A

Ad.8 Additional Information/Comments: N/A